OAHU REGION
HAWAII HEALTH SYSTEMS CORPORATION

BED-HOLD AGREEMENT

I, _____ , resident of this facility being discharged on _____.

acknowledge that I have been given Notice of the facility's Bed-Hold and Readmission policy.

I **AGREE/DISAGREE (circle one) to Bed-Hold for _____ days** and to pay the daily rate* of $_____ for the current room accommodation, effective the date after discharge, for the period from _____ to _____ **OR** until date of cancellation.

_____ _____
Signature of Resident *Date*

_____ _____
Signature of Witness *Date*

RESIDENT REPRESENTATIVE

On behalf of _____ , resident of this facility being discharged on _____, I, _____ resident's representative, acknowledge that I have been given Notice of the facility's Bed-Hold and Readmission policy.

I **AGREE/DISAGREE (circle one) to Bed-Hold for _____ days** and to pay the daily rate* of $_____ for current room accommodation, effective the date after discharge, for the period from _____ to _____ **OR** until date of cancellation.

_____ _____
Signature of Resident's Representative *Date*

_____ _____
Signature of Witness *Date*

*Skilled or Intermediate Level of Care in private, semi-private, or ward accommodation

Amount due is _____ days at $_____ per day for a total of $_____ .

If additional days are necessary, a new Bed-Hold Agreement must be executed.

Return form and payment payable to the appropriate facility below within 24 hours of resident's discharge.

☐ Leahi Hospital Call Business Office 733-7960 or Nursing Supervisor 220-3798 for information
☐ Maluhia Call Financial Counselor 832-6136 or Nursing Supervisor 832-6177 for information

Original - Medical Records
Copy - Resident/Responsible Party & Business Office.

LEAHI HOSPITAL | 3675 KILAUEA AVENUE | HONOLULU, HAWAII 96816 | PHONE (808) 733-8000 | FAX (808) 733-7914
MALUHIA HOSPITAL | 1027 HALA DRIVE | HONOLULU, HAWAII 96817 | PHONE (808) 832-3000 | FAX (808) 832-3897